Financial Policies and Procedures
Medical Care Debts

CHAPTER 5

0501 OVERVIEW

This chapter establishes the Department of Veterans Affairs (VA) financial policies and procedures relating to the collection of debts owed to VA as a result of the receipt of medical care or services from VA that are deposited to the Medical Care Collections Fund (MCCF).

050101 AUTHORITY FOR MEDICAL CARE DEBT COLLECTION. VA is authorized by 38 U.S.C. Chapter 17 to recover the reasonable cost of medical care furnished to a Veteran for the treatment of a nonservice-connected (NSC) disability or condition when the Veteran or VA is eligible to receive payment for such treatment from a third party. VA is also authorized to provide emergency and humanitarian medical care to individuals who may not be eligible for such care or whose eligibility has not been confirmed. In addition, VA is authorized to charge some Veterans copayments for inpatient or outpatient health care, medications or extended care services.

050102 ACTIONS FOR MEDICAL CARE DEBT COLLECTION. VA recovers medical care costs through assessing fees, referred to as copayments, to Veterans who receive health care at VA facilities (or non-VA facilities for which VA has paid for treatment rendered) on an inpatient or outpatient basis or for extended care services and medications. VA advises the Veteran of his or her responsibility for copayments for medical services received and follows up on a regular basis to ensure the debt is collected. VA prepares claims to collect medical care costs from third parties based on VA's reasonable charges for non-service connected care. A Veteran's copayment charge may be satisfied or reduced if a payment is received from a Veteran's third party health insurance.

0502 POLICIES

050201 AUTHORITY FOR MEDICAL CARE DEBT COLLECTION.

A. Reimbursable Medical Health Care. VA will recover the cost of certain health care and services as authorized in existing legislation (38 U.S.C. 1729).

B. Copayments. VA collects certain fees, referred to as *copayments*, from certain Veterans who receive inpatient or outpatient health care, medications or extended care services. Such debts are subject to interest, late payment charges and referral for collection purposes.

C. Emergency and Humanitarian Medical Care. VA will render medical care or services under emergency or humanitarian conditions to individuals not eligible for such care or services. Such debts are subject to interest, late payment charges and referral for collection purposes. These debts are not eligible for waiver consideration but may be compromised (38 U.S.C. 1784).

D. Debt Collection Process. VA will carry out its debt collection process when debts are not being repaid in a timely manner, adhering to the debt collection standards in U.S. Code, VA regulations and Volume XII, Chapter 1. As part of this process, VA will advise debtors of their due process rights relating to various activities associated with debt collection.

050202 ACTIONS FOR MEDICAL CARE DEBT COLLECTION.

A. First Party Copayments. If a Veteran's medical care appears to qualify for billing under reimbursable insurance and copayment, the charges for copayments will be placed on hold for 90 days, pending payment from the third party payer. If no payment is received within 90 days, then the charges will automatically be released and a statement generated to the Veteran. VA will provide sufficient information about first party copayment debts to Veteran patients reminding them of their responsibilities to pay their share of debts created from medical services rendered as inpatient, outpatient, extended care or medication. VA will follow up with the debtor until the debt is resolved.

B. Third Party Receivables. VA will prepare claims to collect certain accounts receivable from appropriate third parties in accordance with 38 U.S.C. 1729.

C. Third Party Receivables (Regional Counsel). VA will prepare claims to obtain reimbursement from appropriate third parties for third party tortfeasor, workers' compensation and no-fault insurance claims. The receivables are under the exclusive jurisdiction of VA’s Regional Counsels (RC).

D. Multiple Category Claims Processing. If the cost of a Veteran's medical care appears to qualify for reimbursable insurance billing and copayment, the charges for copayments will be placed on hold for 90 days, pending payment from the third party payer. If no payment is received within 90 days, then the charges will automatically be released and a statement generated to the Veteran. On all third party payments, the entire amount of the payment will be applied first to the corresponding copayment. The Veteran is then billed for the portion of the copayment not covered by the insurance reimbursement and the portion of the copayment for any non-covered services.

E. Recording Third Party Receivables. VA will record third party accounts receivable for claims generated for medical care and any claim settled in full or an amount less than the claim and requiring an accounting adjustment.

0503 AUTHORITY AND REFERENCES

050301 31 U.S.C. Chapter 37, Subchapter II, Claims of the United States Government

050302 38 U.S.C. 1503, Determinations with Respect to Annual Income

050303 38 U.S.C. 1521, Veterans of a Period of War

050304 38 U.S.C. 1710, Eligibility for Hospital, Nursing Home and Domiciliary Care

050305 38 U.S.C. 1710B, Extended Care Services

050306 38 U.S.C. 1722A, Copayments for Medications

050307 38 U.S.C. 1729, Recovery by the United States of the Cost of Certain Care and Services

050308 38 U.S.C. 1784, Humanitarian Care

050309 42 U.S.C. 2651, Federal Medical Care Recovery Act, Recovery by United States

050310 31 C.F.R. Chapter IX, Federal Claims Collection Standards (Department of the Treasury--Department of Justice)

050311 38 C.F.R. Part 1, Section 1.900-1.953, Standards for Collection, Compromise, Suspension or Termination of Collection Effort and Referral of Civil Claims for Money or Property

050312 38 C.F.R. 17.43(b) (1), (2) and (3), Persons Entitled to Hospital or Domiciliary Care

050313 38 C.F.R. 17.102(a), Charges for Care or Services

050314 OMB Circular A-129, Appendix A, Paragraph V, Delinquent Debt Collection

050315 Treasury Financial Manual, Volume 1, Part 6, Chapter 8000, Section 8025.30 Collection Mechanisms

050316 Department of the Treasury Guide: Managing Federal Receivables

0504 ROLES AND RESPONSIBILITIES

050401 The Assistant Secretary for Management/Chief Financial Officer (CFO) oversees all financial management activities relating to the Department's programs and operations, as required by the Chief Financial Officers Act of 1990 and 38 U.S.C. 309. Responsibilities include the direction, management and provision of policy guidance and oversight of VA's financial management personnel, activities and operations. The CFO establishes financial policy, systems and operating procedures for all VA financial entities and provides guidance on all aspects of financial management.

050402 Under Secretaries, Assistant Secretaries, Chief Financial Officers, Fiscal Officers, Chief Accountants and other key officials are responsible for ensuring compliance with the policies and procedures set forth in this chapter.

050403 The Chief of the Finance Activity is solely responsible and accountable for all requirements outlined in this chapter, regardless of the organizational alignment of the unique functions or activities and therefore will ensure that appropriate procedures are followed when collecting medical care debts.

050404 The Debt Management Center (DMC), located in St Paul, MN, is responsible for offsetting Veterans' compensation and pension benefits in instances of unpaid first party copayment debts.

050405 The Consolidated Patient Accounts Centers (CPAC) were authorized by the Veterans' Mental Health and Other Improvements Act (Public Law 110-387). The centers reengineer and integrate all business processes of the VA revenue cycle, standardize and coordinate all VA activities related to the revenue cycle for all health care services furnished to Veterans for non service-connected medical conditions, apply commercial industry standards for measures of access, timeliness and performance metrics with respect to VA revenue enhancement, and apply other requirements with respect to such revenue cycle improvement as deemed necessary. The CPAC initiative will consolidate traditional VHA business office functions into seven regional centers with the goal of transforming VHA billing and collections activities and more closely align VHA with industry best practices. Each CPAC includes a fiscal officer who retains fiscal authority over the facility.

050406 Regional Counsels (RC) and designated staff attorneys are authorized, in any matter within the jurisdiction of the VA General Counsel, delegated or otherwise assigned, to conduct investigations, examine witnesses, take affidavits, administer oaths and affirmations and certify copies of public or private documents. The RC is authorized, under the guidance of the General Counsel, to provide legal services, advice, and assistance to VA installations within the region assigned. In any area of regulatory, assigned or delegated responsibility, the RC may delegate to staff members or other VA attorneys authority to perform, to the extent specified, any legal function under the professional direction of the RC. The RC may modify, suspend or rescind any authority delegated hereunder.

0505 PROCEDURES

050501 AUTHORITY FOR MEDICAL CARE DEBT COLLECTION.

A. Reimbursable Medical Health Care. VA will recover certain health care and services costs as authorized in 38 U.S.C. 1729.

1. Subject to the provisions of appropriations acts, amounts in the MCCF will be available, without fiscal year limitation, to the Secretary for furnishing medical care and services for the same purposes and subject to the same limitations (other than with respect to the period of availability for obligation) as apply to amounts appropriated from the general fund of the Department of the Treasury (Treasury) for that fiscal year for medical care.

2. VA will implement the provisions of 38 U.S.C. Chapter 17, to include assessing fees for the cost of medical care and services rendered to Veterans, collecting copayments for medications, receiving reimbursement for humanitarian or emergency care treatment and depositing the funds in the MCCF 36 5287.

a. VA is authorized to recover the reasonable cost of medical care furnished to a Veteran for the treatment of a NSC disability or condition when the Veteran or VA is eligible to receive payment for such treatment from a third party (38 U.S.C. 1729).

(1) Funds collected from the following are credited to MCCF 36 528704;

- Third party payers for the treatment of insured Veterans for NSC care;
- Non-Federal Workers' Compensation programs;
- No-Fault Auto Insurance;
- Third Party Tortfeasor claims;

(2) Funds collected from Third Party payer for prescription claims are credited to MCCF 36 528711 (see Appendix B);

(3) Funds collected for the following are credited to Medical Services 36_0160;

- DoD sharing arrangements;
- TRICARE;
- Ineligible hospitalization;
- Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA);
- CHAMPVA third party; and

(4) Funds collected under the Federal Medical Care Recovery Act (42 U.S.C. 2651 et seq.) by the CHAMPVA office (Denver, CO) are credited to MCCF 36 528704.

b. VA is authorized to collect copayments from certain Veterans who receive inpatient or outpatient health care at its facilities (38 U.S.C. 1710(a) (3), (f)). In addition to the copayment, Veterans are also required to pay a $10 per diem copayment for each day of inpatient hospital care, starting on the first day of care. Funds collected for the copayments and for the additional per diem charges are credited to MCCF 36 528703.

c. VA is authorized to collect copayments from certain Veterans who receive extended care services (38 U.S.C. 1710B). Funds collected for the copayments and for the additional per diem charges are credited to MCCF 36 528709.

d. VA is authorized to charge certain Veterans who receive medications on an outpatient basis for treatment of NSC conditions a copayment for each 30-day-or-less supply of medication provided (38 U.S.C. 1722A). Veterans are exempt from the copayment requirement for medications if they are:

- receiving medications for treatment of service-connected conditions;
- rated 50 percent or more service-connected;
- former Prisoners of War;
- treated under certain other special authorities; or
- if their annual income (as determined under 38 U.S.C. 1503) does not exceed the maximum annual rate of pension that would be payable to the Veteran if he/she were eligible for pension under 38 U.S.C. 1521.

e. Funds collected for medication copayments are credited to MCCF 36 528701.

f. Funds collected for emergency humanitarian care, whether paid by the patient or their insurance are credited to MCCF 36 528703.

B. Emergency and Humanitarian Medical Care.

1. VA is authorized in accordance with 38 C.F.R. 17.43(b) (1), (3) to provide medical care or services to the general public and employees and their families in an emergency or on a humanitarian basis. Billing for such care is authorized in 38 C.F.R. 17.102(b). If a person provides their health insurance information, VA may bill the health insurance and balance bill the individual for the amount not paid by the individual's health insurance. If a person does not have health insurance information, a form letter will be sent to the person treated requesting payment for medical care or services provided to that person.

2. VA is authorized in accordance with 38 C.F.R. 17.43(b)(2) to provide medical care or services to a person – thought to have been discharged or retired from the Armed Forces – in an emergency. The person will be billed for medical care or services if it is subsequently determined that he or she was not eligible for treatment by VA. Billing for such care or services is authorized in 38 C.F.R. 17.102(a). If a person provides their health insurance information, VA may bill the health insurance and balance bill the individual for the amount not paid by the individual's health insurance. If a person does not have health insurance information, a form letter will be sent to the person treated requesting payment for medical care or services provided to that person.

3. Interest and other late-payment charges are to be assessed on these debts as prescribed in Volume XII Chapter 1A, *Interest, Administrative Costs and Penalty Charges*.

4. Compromise offers received on emergency or humanitarian medical debts will be processed in accordance with Volume XII Chapter 1C, *Compromise of Debts.* Referrals to the Treasury Offset Program (TOP) are governed by the procedures in Chapter 1E,

Treasury Offset Program and Treasury Cross-Servicing. The procedures for suspension or write-off of collection action are contained in Chapters 1H, *Suspension of Collection Action and* 1I, *Termination of Collection Action and Debt Close Out*, respectively. Referrals for enforced collection are governed by the procedures in Chapter 1G, *Referrals for Enforced Collection (Litigation).*

C. Debt Collection Activities. VA will adhere to VA's debt collection standards when collecting medical care debts from Veterans who received health care and services from VA medical facilities. It is important that VA advises the debtors of their due process rights.

Refer to Volume XII Chapter 1, *VA Debt Collection Standards* for more information on the standards to be followed by VA in its debt collection process. Refer also to the subchapters under Chapter 1 for delegation of authority responsibilities assigned to various VA officials for various actions relating to debt collection, including waiver, suspension, compromise, termination of collection action, voluntary and involuntary offsets and referrals of debts to Treasury or the Department of Justice (DOJ).

050502 ACTIONS FOR MEDICAL CARE DEBT COLLECTION.

A. First Party Receivables. VA will provide information to Veterans regarding their responsibilities for first party copayments (inpatient, outpatient, extended care services, medication and per diem). Veterans who do not have health insurance should have the opportunity to satisfy these obligations at the Agent Cashier's office prior to leaving the medical facility.

1. Claims Generation. First party copayments will automatically be generated by the Integrated Billing system. If there is health insurance, these charges are placed on hold for up to 90 days to allow the insurance carrier claims to be generated. Once a claim is generated and payment is not received within 90 days, the copayment will automatically be released by the system and appear on the Veteran's next monthly billing statement.

a. Statements will be sent each month until the debt is resolved or other action becomes necessary.

b. If patients have no additional activity on their accounts, they will receive only three statements. The statements will no longer be generated once a patient has gone through three statement cycles with no activity.

2. Claims Follow Up. VA will monitor the copayment debt collection activity and will perform necessary follow up actions through the following methods.

a. Information is automatically generated from the Veterans Health Information Systems and Technology Architecture (VistA) accounts receivable system for each VHA medical facility and forwarded to the Austin Information Technology Center (AITC) where monthly statements are produced for first party copayment debts through the Consolidated Copayment Processing Center (CCPC). The statements include new

charges, unpaid balances, assessed interest and other late-payment charges. The statements are sent every 30 days unless there has been no activity for an additional 60 days. Interest and administrative charges will continue to accrue each month in the VistA accounts receivable system.

b. Delinquent first party copayment debts will be referred monthly to the DMC if accounts are eligible for referral. To be eligible, the accounts will have:

- a balance of $25 or more (may consist of one or more aged receivables);
- an "active" status; and
- 30 days or more have passed since the third statement was mailed.

If the debtor is matched to Veterans in receipt of VA monthly benefits, the DMC will offset the Veteran's award check. All accounts that do not match those receiving VA benefit checks are returned to the facility and, if appropriate, referred to Treasury for the Treasury Offset Program (TOP). The debt will be referred to TOP after:

- three statements have been sent (along with the other referral criteria mentioned above for DMC offset);
- the debt has been rejected by the DMC as not having an available compensation and pension debt to offset; and
- the debt is at least 180 days delinquent.

Accounts in referral status to DOJ will not be referred to TOP. The VistA system does not allow automatic copayment referral to the DMC or TOP for Veterans with a service-connected rating of 50 percent or greater or for those in receipt of a VA pension. A manual review must be completed and if determined to be appropriate, charges will be verified and then referred to DMC.

3. Referrals to the RC/DOJ. First party copayment receivables will be referred for enforced collection (Litigation) as prescribed in Volume XII Chapter 1G, *Referrals for Enforced Collection (Litigation)*.

4. Write Off. The Fiscal Officer, including the CPAC Fiscal Officer or their designees, may either write off or refer for write-off, any delinquent first party copayment debt that meets the criteria set forth in Volume XII Chapter 1I, *Termination of Collection Action and Debt Close Out*. Write-off of any copayment debt may be accomplished by delegation to the revenue program, even if they do not directly report to the Finance Activity; however, the responsibility and accountability remains with the Finance Activity, including CPAC finance activity.

5. Waiver. The Fiscal Officer, including the CPAC Fiscal Officer or their designees, may waive delinquent first party copayment debt that meets the criteria set forth in Volume XII Chapter 1B, *Waiver of Debts*.

6. Interest and Administrative Costs. Interest and other late-payment charges are assessed on delinquent first party copayment debts as prescribed in Volume XII Chapter 1A, *Interest, Administrative Costs and Penalty Charges*.

B. Third Party Receivables Under the Jurisdiction of the Fiscal Activity. VA will prepare claims under the jurisdiction of VA's Finance Activities, including CPAC finance activities, to obtain reimbursement from appropriate third parties.

1. Bill Generation. The billing office will prepare claims on standard medical claim billing forms to notify appropriate third parties of accounts receivable established for VA-provided reimbursable medical care. Medical record documentation will not be provided to the third party payer unless requested (e.g., discharge summary from VistA Computerized Patient Record System (CPRS)). It is not necessary to attach medical record documentation when submitting a claim.

a. The billing unit may be local and consolidated within the Finance Activity or separate and distinct from the Finance Activity or it may be a part of CPAC.

b. The bill will be sent to the third party payer once it has been generated and audited by the Finance Activity.

c. The Chief of the Finance Activity, including CPAC Finance Activity, is responsible for the billing accuracy regardless of the billing unit status.

2. Claims Follow Up. The appropriate staff will follow up on unpaid third party insurance cases according to the guidelines in Appendix A. VHA may use contractors to assist with follow-up and collection from third party payers. VHA has some national blanket purchase agreements available and many facilities/VISNs also contract on their own.

a. If the claim was submitted to the Medicare Fiscal Intermediary and no response is received within 30 days after submission, then stations are required to follow up.

b. All third party claims follow-up conducted via telephone or online inquiry will be documented in the VistA Third Party Joint Inquiry (TPJI), as follows:

(1) If follow-up is conducted via telephone, documentation should include the name of the payer, title and telephone number of the person contacted, the date of contact, the claim reference number provided by the payer and a brief summary of the conversation.

(2) If follow-up was conducted via an online query, documentation should include the URL or Web site name and payer name, the date of the query, claim reference number provided by the payer and a brief summary of the information provided.

c. Although not preferred, if letters are sent via mail or faxed for follow-up, a file copy will be retained. The date the letter was sent, along with mailing address or fax number, will be noted in the comments.

d. Written documentation within TPJI will be the only approved record of follow-up activity.

e. Whenever notification is received from a third party payer that zero payment will be made due to deductible or co-insurance, this information will be included with the follow-up comments and the account will be closed. The comment should clearly state that this is zero pay due to deductible and/or coinsurance and will include the reference number provided by the payer and proper Health Insurance Portability and Accountability Act (HIPAA) standard adjustment code.

Whenever notification is received from a third party payer that a partial payment will be made at a future date, this information should be included with the follow-up comments and the account can be decreased to the amount of the expected partial payment (using a decrease adjustment transaction) in the VistA AR system. The comment should clearly state that this is due to expected partial payment and will include the reference number provided by the payer and expected payment date for the remaining payment. An example: third party payer indicates that they will pay $400 of a $1000 receivable, however, the agreed upon amount will be paid at a determinable time in the future. In these instances the receivable can be decreased by the $600 that will not be paid. The bill will remain open/active for the $400 until payment is received. Do not post the actual collection until it is received.

Whenever notification is received from a third party payer that a claim has been paid, VA records are to be examined to determine if payment was received. If there is no evidence of payment:

(1) If the payment was made via an electronic payment, ask the payer for the date of the Electronic Funds Transfer (EFT), trace number and the amount of the EFT. Review the Daily Activity Report to locate the EFT in VistA. If unable to locate it in VistA, review the Explanation of Benefits and Payments, Healthcare Resolution Application (EPHRA) to locate the EFT. If EFT is in EPHRA, but not in VistA, contact Enterprise Product Support (EPS) to request the EFT be retransmitted. If the EFT is not in VistA or EPHRA, complete the “ePayments Problem Reporting Form” and forward the form to your ePayments’ Veterans Integrated Service Networks/Point of Contact (VISN/POC). VISN/POCs will forward the research request through the appropriate channels at the PNC Bank.

(2) If payment was made via check, ask the third party payer to either send a copy of the canceled check image or provide the check number and the date of the check. When a third party payer provides a copy of the canceled check image or check number and date of check, prompt action will be taken to ensure that the appropriate payment was applied to the correct receivable.

f. Contact the third party payer for reimbursement for monies paid to a subscriber. The Veteran may also need to be contacted. If the Veteran provides the insurance check or pays with funds from the insurance check, a comment will be made in TPJI, stating the check number, date of the check, etc. This will ensure a true audit trail. Written documentation within TPJI will be the only approved record of follow-up activity. If the insurance company refuses to pay, facilities are to contact the RC in writing for guidance. It is important to address these issues promptly and resubmit the claim for payment, if appropriate.

g. When a third party payer denies the claim, the Explanation of Benefits (EOB) or other information provided by the payer should be reviewed by appropriate staff, which may include accounts management, Utilization Review (UR) Nurse, the revenue supervisor or other designated staff. If the denial correctly identifies a billing error involving patient registration or demographic data, including specifics of the Veteran's insurance coverage (verification), the Accounts Receivable staff will communicate in writing to the staff responsible for the accuracy of the patient database to make the appropriate corrections. If it is determined that the claim denial is unjustified, the revenue staff should contact the third party payer to request reconsideration. Following reconsideration, if the third party payer agrees the claim was denied in error, a request for the claim to be reprocessed will be made. If the payer will not automatically reprocess the claim, the claim will need to be resubmitted to the third party payer. If the third party payer maintains that the claim denial was justified, the revenue staff may appeal the decision. When it is determined that part of or the entire claim is not valid, billers will use the VistA CLON Copy/Cancel option for resubmission of the claim or VistA CANC Cancel Bill option as appropriate. If an appeal is in progress, research is being performed or a claim is being resubmitted, this information will be documented in TPJI to demonstrate that VA is working on the claim.

h. If there is no response from the third party payer within the timeframes in the Table in Appendix A, additional follow-up as required will be completed. Written documentation within the TPJI menu will be the only approved record of follow-up activity.

i. Once all required follow-ups have been completed and all administrative remedies exhausted (such as appeals), the revenue supervisor should contact RC for guidance (see paragraph 050502B4 below) prior to referring the case to RC. Referrals to RC should include information about the patient's health insurance policy, copies of any written or electronic correspondence, copies of all denials received from the third party payer, summaries of follow-up activities with the third party payer and a summary of all

actions taken by the revenue staff to collect from the insurance company, to include any actions taken by a collection agency.

j. In all cases involving the write-off of any debt, the Fiscal Officer, including the CPAC Fiscal Officer or their designees, is solely responsible and accountable to ensure that all write-off activity conforms to the applicable regulations and directives. Write-off of third party accounts receivable may only be approved in advance by the Office of General Counsel (OGC).

3. Payment.

a. Payment in full will close the case.

b. Partial payment by a third party payer under the terms of the applicable insurance policy or other agreement will normally be accepted as payment in full, thereby closing the case. The balance (unpaid amount) is to be contractually decreased. However, if there is a question as to the validity of the reason given by the third party payer for reduction of the reimbursed portion of the claim or if there is a considerable difference between the amount collected and the amount established as the accounts receivable, the revenue staff should take the following action(s):

(1) Review the EOB to determine if the payment is paid in accordance with the Veteran's health benefit coverage.

(2) If it is determined a potential error in the claim payment exists, the Accounts Receivable staff will contact the third party payer. When the third party payer agrees that the original claim was not paid correctly, request the payer reprocess the claim. If the payer cannot reprocess it, the claim should be resubmitted immediately for additional payment. If the third party payer maintains that the claim was paid correctly, request the advice of the revenue supervisory staff. If the supervisor agrees, the balance of the claim is to be contractually adjusted. Claims processed under the Coordination of Benefits (COB) rules will be evaluated based on the health insurance plan. However, if the revenue supervisor is still uncertain as to whether the claim was properly adjudicated, he/she should request advice from the Regional Counsel (RC).

The contractual adjustment will be completed within 5 business days after the payment has been applied. A comment should be entered explaining the reason for the contractual adjustment.

4. Referrals to the RC. Individual third party receivables are referred to the RC for review and advice as to how to handle collection procedures in cases where there are potential legal action activities (see paragraph 050502B2i above).

a. After all required follow-up efforts have been made by the revenue staff, third party claims will be referred to the RC for appropriate action under the following conditions:

(1) Litigation Issues. Refer bill if payment is denied because of VA-related litigation.

(2) Veteran Not Responsible for Cost of Care. Refer bill if payment is denied by the third party payer because Veteran is not required to pay VA for the care provided by VA.

(3) Refusal to Pay Government Hospital. Refer bill if payment is denied because third party payer states they are not required to pay a Government hospital/facility.

(4) Veteran Paid Directly. Refer bill if payment is sent to the Veteran instead of VA and contacts have been made to the insurance company and Veteran without any action.

(5) Revenue Supervisor Referral with RC Consent. The revenue supervisor will contact the RC for approval to forward other significant issues for review other than those noted above in paragraphs 050502B4b(1)-(4).

PLEASE NOTE: The VistA referral code is a restricted menu option that is available only to the revenue supervisor. A mandatory comment will be entered into this option and it will contain the date, time and name of the person the revenue supervisor spoke with at the RC.

b. Individual third party receivable cases should not be closed in the VistA accounts receivable package. If appropriate, the RC will forward such receivables to OGC to review for possible litigation. Documentation will be submitted with all referrals to the RC.

c. Reasons Not to Refer to RC. Third party claims will not be referred to the RC for the following reasons unless the revenue supervisor has consulted with the RC and the RC has agreed to accept the referral:

(1) Medical Necessity/Emergency Denials. The insurance company determines that the medical treatment was not a medical necessity within the policy guidelines or a legitimate emergency, as required by most health maintenance organizations.

(2) Pre-authorization/Pre-admission Certification Denials. The care was not pre-authorized or pre-certified, as required by the insurance company and no payment or a reduced payment was made in accordance with the insurance policy.

(3) Insurance Deductibles. The claim was approved or partially approved, but the payment was applied to the deductible.

(4) Maximum Benefits Used. The insurance company has a dollar or visit ceiling and the maximum was met or exceeded the limits of the policy. This includes “lifetime ceilings.” An example is a limit on the number of outpatient visits for mental health allowed each calendar year.

(5) Reasonable and Customary Rates. The insurance company has paid on the basis that their rates are the same as what is paid to other providers in the community and demonstrated that to the satisfaction of the VA.

(6) Length of Stay. The insurance company pays on the basis of an appropriate determination of length of stay and the Veteran's stay extends beyond the terms of the insurance policy.

(7) Level of Care, Acute vs. Non-Acute Coverage and Nursing Home Coverage vs. Skilled Nursing Home Coverage. The carrier's payment (or lack thereof) is based upon an appropriate determination that the level of care exceeded the level that was medically necessary.

C. Third Party Receivables Under the Jurisdiction of the Regional Counsel. VA collects certain accounts receivable from appropriate third parties under the jurisdiction of the RCs.

1. Claims Generation. The billing office will prepare claims, addressed to the appropriate RC, to recover payments from third parties for accounts receivable established for Tortfeasor, Workers' Compensation (non-Office of Workers' Compensation and Pension) and No-Fault Auto Insurance claims. The claims will be audited and forwarded to the RC for appropriate action.

2. Claims Follow Up. RCs will follow up on unpaid accounts receivable under their jurisdiction.

3. Payments. RCs will forward all payments, on the same day received, for immediate deposit to the Agent Cashier at the station where the charges originated. The transmittal notice to the Agent Cashier will clearly state that the amount received is full or partial settlement and will list the related charges.

a. If a payment is received at a facility, the facility will contact the RC and funds will be deposited without being sent to the RC.

b. All accounts paid in full will result in a closed case.

4. Decreases. Unpaid third party accounts receivable will be decreased to zero if they meet one or both of the following criteria:

a. Payment is accepted for less than the amount of the original claim as a compromise; or

b. Claim has been referred to the RC for review and advice as to how to handle collection procedures; no response or payment is received; and the RC advises that the claim amount is uncollectible.

D. Multiple Category Claims Processing.

1. Copayments and Reimbursable Insurance. If a Veteran's medical care appears to qualify for reimbursable insurance and copayment, the charges for copayments will be placed on hold for 90 days, pending payment from the third party payer. If no payment is received within 90 days, the charges will automatically be released and a statement will be generated to the Veteran.

a. For insurance company payments, the amount of the payment for the specific episode of care on a particular date of service will be applied to the first party bill for the same episode of care and date of service.

b. The EOB should be examined carefully to ensure appropriate accounting of remittance.

c. The Veteran is then billed for the portion of the copayment not covered by the insurance reimbursement and the portion of the copayment for any services not covered at all by third party insurance.

2. Non-Federal Workers' Compensation, Tortfeasor and No-Fault Auto and Copayment. The Claims activity will prepare a claim to the third party payer for all the medical care provided for non-Federal Workers' compensation, Tortfeasor and No-Fault Auto claims and will bill the Veteran for the copayment at the same time. The claim form for non-Federal Workers' compensation, third party Tortfeasor and No-Fault Auto claims will include the following statement: "Gross amount includes the copayment." If the Veteran pays the copayment and all or a portion of the copayment is recovered from the third party payer, a refund to the Veteran is to be made promptly.

E. Recording Third Party Receivables when there are multiple third party payers.

1. When a bill is generated, an accounts receivable is recorded for the claim rendered for third party medical care, including Workers' Compensation, No-Fault Auto, Tortfeasor, reimbursable insurance cases and medical riders on a patient's homeowners' policy.

2. Payments received for less than the claim amount, accepted as full settlement of the claim, are to be contractually adjusted and closed.

3. The revenue staff will ensure that duplicative payments are not received for the same episodes of care through a COB review of accounts receivable. COB is a common provision in most health benefit plans and the majority of health benefit plans use the benefit determination rules established by the National Association of Insurance Commissioners. A COB duplicate payment may occur when a Veteran has other insurance coverage that is primary, such as another health care plan, Medicare, motor vehicle insurance for medical expenses or workers' compensation. Generally, a Veteran's primary health insurance plan will not provide primary coverage if recovery is available from another source. In this instance, the Veteran's primary plan is a secondary payer and payment, if any, is based on the payment that was made or

should have been made, by the other insurance. There are two types of COB provisions used by secondary claim payers when paying COB claims:

- A non-duplication COB provision, in which the secondary claim payer pays the difference between the normal allowed amount and the primary carrier's payment; and

- Where the secondary claim payer pays the difference between the total amount of the claim and the primary claim payer's payment when reimbursement also has been received from a third party health plan. The COB requirements in many plans, as well as in State law, may create an obligation to refund.

In all such cases, the RC, who has jurisdiction of tortfeasor, non-Federal workers' compensation and No-Fault Auto claims, should be consulted for determination of these issues. The Fiscal Officer is responsible for ensuring that VA has not received two payments for the same episode of care and the COB review.

0506 DEFINITIONS

050601 Close out. Occurs when an agency, after determining that additional future collection efforts on a debt would be futile, reports the amount of a terminated debt to the Internal Revenue Service (IRS) as potential income to the debtor on Form 1099-C, Cancellation of Debt. For debts that are not reportable to IRS, close-out never actually occurs.

050602 Compromise. An offer and acceptance of a partial payment in settlement and full satisfaction of the offeror's indebtedness, as it exists at the time the offer is made. It is a final settlement, binding on the parties to the compromise, unless procured by fraud, misrepresentation of a material fact or mutual mistake of fact.

050603 Copayments. Fees charged to recover medical care costs to Veterans who receive health care on an inpatient or outpatient basis at VA facilities or extended care services.

050604 Debts. Claims for money made by or owed to the Government, arising out of activities of VA. Third party receivables (health insurance, tortfeasor, non-Federal Workers compensation and No-Fault Auto claims are not considered debts.

050605 Delinquent. In the case of most administrative debts (e.g., overpayments), delinquency occurs when payment is not made in full or an acceptable repayment plan is not established by the due date specified in the initial billing notice (usually 30 calendar days from the date the Notice of Indebtedness is mailed). For first party medical care debts, delinquency occurs 30 calendar days after a charge first appears on a Patient Statement. In the case of a debt being paid in installments, delinquency occurs when payment is not made by the end of the "grace period" as established in the repayment agreement.

050606 Due Process. Information provided to Veterans, beneficiaries and employees indicating their rights regarding VA's debt collection process.

050607 First Party Copayment Debt. A debt owed by an individual and resulting from the provision of medical care or services under the authority of 38 U.S.C. Chapter 17. These debts include prescription copayments, inpatient and outpatient copayments, per diem charges for hospital care or nursing home care and debts resulting from the provision of care on a humanitarian basis or to individuals who are not eligible for VA medical benefits.

050608 Medicare Fiscal Intermediary. An entity that processes Medicare remittances received from VA.

050609 Offset. The collection of a debt, in part or in full, from moneys a debtor is currently receiving or may receive in the future from the Government.

050610 Suspension. Temporary stoppage of collection actions on a debt owed to VA until some future predetermined time(s) when collection action will be resumed.

050611 Termination of Collection Action. Refers to a decision made to cease active collection action on a debt, in accordance with criteria set out in the Federal Claims Collection Standards, because such action is not economically worthwhile or is otherwise inappropriate. The Federal Claims Collection Standards do not apply to third party receivables (health insurance, tortfeasor, non-Federal Workers compensation and No-Fault Auto claims).

050612 Third Party Claims. Claims against a third party (i.e., insurance company, workers' compensation carrier, employer or other responsible person) for reimbursement to VA for the cost of treating a Veteran for a non-service-connected disability or condition when that party is obligated to provide or pay the expenses of such treatment.

050613 Tortfeasor. A person who commits a civil wrong (breach of a legal duty) which results in damage to another person.

050614 Treasury Offset Program (TOP). Program required by the Debt Collection Improvement Act of 1996 to recover all referred agency debts, delinquent more than 180 days, by offset of tax refunds and other Federal payments, including salary offsets, Federal retirement offsets or vendor offsets. Third party receivables (health insurance, tortfeasor, non-Federal Workers compensation and No-Fault Auto claims) will not be referred to TOP.

050615 Veterans Health Information Systems and Technology Architecture (VistA). VistA is the automated environment supporting day-to-day operations at local VA health care facilities. It is built on a client-server architecture, which ties together workstations and personal computers with graphical user interfaces at VHA facilities, as well as

software developed by local VHA medical facility staff. VistA includes the links that allow commercial off-the-shelf software and products to be used with existing and future technologies.

050616 Veterans Integrated Service Networks (VISN). Veterans Integrated Service Networks are networks of medical centers, Vet centers and outpatient clinics offering primary and specialized care. These networks are grouped into 21 geographic regions and manage nursing homes, readjustment counseling Vet centers and domiciliaries.

050617 Waiver. A decision that conditions exist, under the applicable statutes (38 U.S.C. 5302 and 5 U.S.C. 5584) and implementing regulations (38 CFR 1.955-1.969, 17.105) that prohibit recovery by VA of certain debts as defined in the statutes and regulations, including interest and other late payment charges assessed on such debts. The statutory referenced above does not apply to third party receivables (health insurance, tortfeasor, non-Federal Workers' compensation and No-fault Auto claims).

050618 Write Off. Write-off of a debt should occur when the agency determines that the debt has no value for accounting purposes. All debt will be reserved for in the allowance account and all write-offs will be made through the allowance account. Under no circumstances are debts to be written off directly to expense.

0507 RESCISSIONS

050701 VA Handbook 4800.14, Medical Care Debts

050702 VA Bulletin 08GC1.04, Revised Follow-Up Timelines For Third Party Medical Care Debts

0508 QUESTIONS

Questions concerning these financial policies and procedures should be directed as follows:

VHA	VHA Accounting Policy (Outlook)
All Others	OFP Accounting Policy (Outlook)

0509 REVISIONS

Section	Revision	Office	Effective Date
050502B2e	Revised section to include reducing third party debt in VistA AR system.	APPS (047GA)	May 2012
Appendices A and B	Tables updated	APPS (047GA)	May 2012

APPENDIX A: UNPAID REIMBURSABLE THIRD PARTY INSURANCE CASE – REIMBURSEMENTS DEPOSITED TO MCCF

The following table provides guidelines for follow up on unpaid reimbursable third party insurance cases where reimbursements are deposited to the Medical Care Collection Fund (36 5287).

All references to days for follow-up are calendar days. If a follow-up timeline falls on a weekend or Federal holiday, the follow-up would move to the next business day. In addition, if a partial payment has been received, the residual balance is used to determine the dollar category for additional follow-ups.

DOLLAR VALUE	FIRST FOLLOW-UP	ADDITIONAL FOLLOW-UPS
<$51	No Follow-up unless resources permit.	No follow-up unless resources permit.
≥$51 to <$250	1st Follow-up within 90 days after the initial bill was generated.	One additional follow-up based on results of the previous follow-up which will be documented in the VistA Third Party Joint Inquiry (TPJI) menu. When a follow-up query is made, a comment with the follow-up date should be entered into the TPJI menu.
≥$250 to <$1,500	1st Follow-up within 60 days after the initial bill was generated.	One additional follow-up based on results of the previous follow-up which will be documented in the VistA TPJI menu. When a follow-up query is made, a comment with the follow-up date should be entered into the TPJI menu.
≥ $1,500	1st Follow-up within 45 days after the initial bill was generated.	Additional follow-up based on results of the previous follow-up which will be documented in the VistA TPJI menu. There will be at least two additional follow-ups after the first follow-up if payment is not received. When a follow-up query is made, a comment with the follow-up date should be entered into the TPJI menu.
Paper Pharmacy Bills	1st Follow-up within 120 days	No additional follow-ups.

APPENDIX B: FUNDS FOR DEPOSITS AND REFUNDS AND ASSOCIATED ADMINISTRATIVE FUNDS

The following table depicts the funds used for deposits and refunds for Medical Care Collections and the associated administrative funds.

RECEIVABLE TYPE	FUND COLLECTIONS DEPOSITED	FUND REFUNDS RECORDED
Administrative Charges Paid on Receivables	36_3220	20X1807
Extended Care Copayments (Long Term Care)	36X528709	36X528709
First party Medication Copayments	36X528701	36X528701
First party Medical Care Copayments	36X528703	36X528703
Funds Deposited to Suspense	36F3875	36F3875
Interest Paid on Receivables	36_1435	20X1807
Marshall Fee and Court Cost	36X0869	36X0869
Third Party Reimbursable Insurance (includes non-Federal Workers' Compensation, Tortfeasor and No-Fault Automobile Insurance claims)	36X528704	36X528704
Third Party Payer for Prescription Claims	36X528711	36X528711
Treasury Offset Program (TOP) Fee	None	36X0160X4